STCC
Springfield Technical Community College

One Armory Square
Suite 1 • PO Box 9000
Springfield, MA 01102-9000
(413) 781-7822 • www.stcc.edu

Office of Disability Services General Disability Verification Form

To determine eligibility and ensure provision of appropriate academic accommodation(s) through the Office of Disability Services, STCC requires students to provide current, comprehensive documentation of disability. The ADAA (Americans with Disabilities Act Amendments Act) defines a disability as a physical or mental impairment that substantially limits one or more major life activities. Comprehensive documentation includes a diagnosis, a DSM-5 diagnosis, if appropriate, and the severity and limitations to functional activities. Documentation must be completed by an appropriately credentialed practitioner (an impartial individual who is not a student's family member).

This verification form supports eligibility for the following conditions: psychiatric disabilities, including ADHD and addiction/recovery, visual disabilities, hearing impairments, and physical and medical-related disabilities.

STUDENT: Please complete the consent for release of information:

I, _____, authorize the release of the following information to the Office of Disability Services at STCC to be used to determine my eligibility for academic accommodations.

_____

Street address City State Zip

_____ (_____)_____

Student signature Date of birth Student ID # Phone

CREDENTIALED PRACTIONER: Please complete in full the disability verification:

Please note that the final determination of appropriate academic accommodations is decided by the STCC Office of Disability Services in accordance with the mandates of the ADAA.

Primary diagnosis: _____

DSM-V diagnosis(es) as appropriate: _____

Does this condition substantially limit the student? **Yes** **No**

Date of original diagnosis: _____

Date of last office visit: _____

List major life activities that are limited: _____

What is the expected duration of this condition? _____

Describe the symptoms associated with this diagnosis exhibited by the student: _____

_____

Identify how this condition may affect the student in an academic setting:

_____

If applicable, list any assistive technology and/or adaptive equipment currently being used, including brand name, model number, and a brief description of the equipment, and suggestions for adaptive equipment in the classroom.

_____

What supports do you recommend that would assist this student in an academic setting (i.e., time-and-a-half for testing, distraction-reduced testing environment, etc.)?

_____

(Functional limitation) (Recommendation)

_____

(Functional limitation) (Recommendation)

Please provide any additional information that would assist in supporting the student, and attach any pertinent evaluations and reports (e.g., visual acuity report, audiological report, etc.).

_____

Optional: List current medication(s) and ***identify how the medication might adversely impact the student in an academic setting:***

_____

Please provide any additional information that would help provide support to the student:

_____

Printed Name of Credentialed Practitioner: _____

Area of Specialty: _____

_____

Street Address City State Zip

_____(_____)_____

Credentialed Practitioner Signature Date Phone

Please attach a copy of your business card and send any additional supporting documentation to:

Office of Disability Services
Springfield Technical Community College
One Armory Square, Suite 1,
PO Box 9000
Springfield, MA 01102-9000
Phone: (413)755-4785 Fax: (413)755-6323
disability_services@stcc.edu